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16. Abstract (Limit: 200 words)

Over the last decade the Health Care Financing Administration, (HCFA) has needed physician practice cost data to fulfill both policy and research objectives. Medicare Part B statistical data derived from administrative systems and claims processing are basically payment data with some beneficiary characteristics. HCFA administrative systems contain no physician practice cost data, unlike hospital cost reports and other facility cost data required to be reported to Medicare. This study is a systematic assessment of current (through 1991) and future physician economic data needs, data sources, and data collection strategies. The methodology included interviews and meetings with HCFA staff members, other Federal agency staff, and staff of other organizations. Face-to-face interviews and meetings were held November 11 - 13, 1991 in Atlanta, Baltimore, and Washington, DC. A structured set of questions were provided to each respondent the week prior to the meeting. Questions addressed the major needs for physician cost (income) data, the kinds of data required, what data are currently available, the strengths and weaknesses of existing data sources, and priorities for future collection efforts. Major ongoing HCFA needs for data identified were the Medicare Economies Index, the Geographic Practice Cost Index, National Health Expenditure estimates, other administrative cost estimates, development of a macro model of the interaction of the health care sector with the rest of the economy, and a wide range of basic research studies. Exhibits are included which list data sources identified and their strengths and weaknesses. Data strategies that could be pursued are to continue to periodically field the HCFA physicians' practice cost and income survey, combine resources with physician organizations who routinely collect data, try Delphi panels/focus groups, or develop cost reports for physician reporting akin to the cost reports required of hospitals.

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hpc

ASSESSMENT OF

PHYSICIAN PRACTICE COST DATA NEEDS

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December 9, 1991

In cooperation with

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Center for
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ASSESSMENT OF PHYSICIAN PRACTICE COST DATA NEEDS

INTRODUCTION

Over the past decade, the Health Care Financing Administration (HCFA) has required physician practice cost data to fulfill both policy and research objectives. For example, physician practice cost data have been used to update the Medicare Economic Index (MEI) and to create the Geographic Practice Cost Index (GPCI) as well as for studies of economies of scale and scope, forecasts of national health expenditures, and analyses of physician income trends. With the phase-in of the Medicare Fee Schedule in 1992, HCFA will have an ongoing need for practice cost information to update and refine the MEI and GPCI; to monitor the impacts of physician payment reform, particularly in areas with high fee reductions; and to refine the non-work components of the fee schedule (e.g., allocating overhead for specific procedures/services).

At this point in time, HCFA requires a coordinated effort to assess its current and future data needs, evaluate the data sources that can be used to meet current data needs, and develop data strategies to meet future data needs. Under a Cooperative Agreement with HCFA, the Center for Health Economics Research (CHER)is conducting such a study. This report provides an assessment of practice cost data needs for physician payment research. The needs assessment is based on interviews with key informants within HCFA and other agencies. The next section describes the methods used to conduct the needs assessment. Then, the practice cost data needs are summarized, followed by an evaluation of the strengths and weaknesses of existing data sources. Finally, possible strategies for fulfilling future data needs are discussed.

METHODS

The needs assessment is based on face-to-face interviews with 12 key informants from the Health Care Financing Administration and 5 individuals from other Federal agencies and organizations (Exhibit 1). Interviews were conducted on November 11, 12, and 13, 1991 in Atlanta, Baltimore, and Washington, D.C.. Interviews lasted between 30 and 90 minutes.

EXHIBIT 1

LIST OF INDIVIDUALS INTERVIEWED FOR NEEDS ASSESSMENT STUDY

Health Care Financing Administration

Office of Research

Nancy McCall
George Schieber
William Sobaski
Sherry Terrell

Office of Demonstrations and Evaluation

Mel Ingber
Mark Wynn

Office of the Actuary

Cathy Cowen
Charles Fisher
Mark Freeland
Katie Levitt
Brenda Maple

Bureau of Policy Development

Terry Kay

Office of the Assistant Secretary for Planning and Evaluation

George Greenberg

Congressional Budget Office

Sandra Christianson

Physician Payment Review Commission

Paul Ginsburg
Roz Lasker

Urban Institute

Stephen Zuckerman

To facilitate the flow of the interview, a set of questions was provided to each individual the week before the interview (Exhibit 2). The purpose of the interview protocol was to familiarize individuals with the content of the interview prior to the date of interview. The interview itself was not structured around the questions. The questions asked participants to consider the major needs for physician practice cost data over the next three years (Q.1), the kind of data required to meet those needs (Q.2), whether the data are currently available (Q.3), and the strengths and weaknesses of existing data sources (Q.4 and Q.5). The final question (Q.6) asked physicians to rank priorities for future data collection efforts. This question elicited primarily qualitative responses about the relative importance of individual data elements, rather than actual numerical rankings. Thus, this report does not include an analysis of the rankings, given the limited number of responses.

DATA NEEDS

Exhibit 3 lists the physician practice cost data needs identified during the interviews with key informants. Most individuals recognized the ongoing need for data for the MEI and GPCI. It was felt that the MEI would most likely be rebased again in 1996, based on PPRC's recommendation of every five years. The one area in which the MEI could be improved is with respect to data on expenses for physician fringe benefits and deferred compensation as well as physician employee expenses.

There was general consensus that the current GPCI needed only minor refinements. Among the suggestions were incorporating the 1990 Census data, refining the malpractice insurance and office space price proxies, examining the assumptions about the national market for equipment and supplies (e.g., volume discounts), and exploring intra-specialty differences in practice costs.

Physician practice cost data are required for national health expenditure estimates in three main areas. First, the Office of the Actuary (OACT) is interested in eliminating the overlap in reported hospital and physician expenditures, for fees provided by hospitals to

EXHIBIT 2

QUESTIONS FOR NEEDS ASSESSMENT INTERVIEWS

1. In your opinion, what are the major needs for physician practice cost data over the next three years? Some examples are: update/refinement of Medicare Economic Index, Geographic Practice Cost Index; forecasting of national health expenditures; basic research on economies of scale/scope in physician practice, urban/rural differences in physician practice costs.

2. What kinds of physician data are required to meet these needs (e.g., physician survey, Medicare claims, in-depth case study)?

3. Are these data available from existing (or ongoing) data sources? If not, how could these data be obtained?

4. What are the strengths of existing data sources on physician practice costs?

5. What are the weaknesses of existing data sources on physician practice costs?

6. What do you think should be the priority of future surveys concerning physician practice costs and incomes? The list below identifies items that have been collected in previous physician surveys. Please rank these items from highest to lowest priority (1 = highest priority). Feel free to specify other items omitted from the list.

   ___ Physician productivity (hours, visits)

   ___ Practice arrangements (multispecialty group, number of physicians, number and mix of non-physician employees)

   ___ Practice costs (physician wages, employee wages, office expenses, malpractice, equipment, supplies, auto, continuing education, miscellaneous)

   Which level of aggregation is preferred?
   (check one)

   ___ Practice level (group)
   ___ Individual physician level

   ___ Practice revenues

   ___ Physician net income

   ___ Medicare/Medicaid participation

   ___ Malpractice insurance (premiums, limits, umbrella coverage)

   ___ Physician fees (self-reported, for selected specialty-specific procedures)

   ___ Physician-hospital relationships (financial arrangements, services provided by hospital, hospital characteristics)

   ___ Public policy impacts (e.g., PPS, MFS)

   ___ Other (specify) _____

EXHIBIT 3

PHYSICIAN PRACTICE COST DATA NEEDS

Medicare Economic Index

- Rebase the MEI (PPRC recommends every five years; next rebasement would be in 1996)
- Improve information on physician fringe/deferred compensation expenses and physician employee expenses

Geographic Practice Cost Index

- Update GPCI with 1990 Census data
- Update malpractice costs
- Refine the office space price proxy
- Examine assumptions of national market for equipment and supplies
- Explore practice cost differentials within selected specialties (e.g., cardiac/thoracic surgery, invasive/noninvasive cardiology, FPs/GPs with and without obstetrics)

National Health Expenditures

- Net out the overlap between hospital and physician expenditures, that is, fees provided to physicians that are not tied to provision of services
- Disaggregate expenditures within service sectors, for example, drug costs by setting (hospitals, physician dispensing)
- Estimate administrative costs, for example, via physician self-reports of administrative hours
- Develop macro model of the interaction of the health care sector with the rest of the economy

Medicare Fee Schedule

- Assess the impact of the Medicare Fee Schedule on physicians in high reduction areas
- Validate (or invalidate) the work estimates developed by Hsiao and colleagues and develop methods for updating work estimates for technology diffusion or introduction of new procedures
- Allocate overhead to individual services/procedures
- Develop bundled payments for outpatient procedures, which would include facility fee, physician fee, and routine ancilary services to develop a "level playing field" across sites

EXHIBIT 3
(continued)

PHYSICIAN PRACTICE COST DATA NEEDS

Practice Arrangements

- Understand how the individual physician relates within a group, in terms of distribution of income, determination of salaries/partnership, and sharing of expenses
- Understand physician-hospital relationships, including compensation arrangements, exclusive contracting, and services provided by hospital

Variations in Physician Practice Costs

- Determine costs associated with efficient practice
- Identify differences in practice costs according to payor mix (Medicare/Medicaid), practice arrangement (solo/small group/large group), managed care involvement
- Assess impact of "efficient practice" reimbursement rates on rural practice, especially very remote rural practices
- Determine site of service differentials in input costs (e.g., inpatient hospital, outpatient hospital, freestanding facility, office)

Medicare in Context

- Analyze revenues costs, prices, and profits for physician sector in general, not just the Medicare piece (the PPS analogy)
- Measure administrative costs of multipayor system

Methodological Needs

- Validate physician self-reported practice costs against external source
- Understand how physicians allocate group costs according to "own" share
- Develop a consistent methodology for follow-up cost studies, particularly to improve the utility of specialty society-sponsored studies

physicians that are not tied to the direct provision of services. Currently, such fees are reported as both hospital and physician expenditures. Second, OACT is striving to disaggregate national health expenditures within and between service sectors. Currently, major categories include hospitals, physicians, and drugs. A future objective, therefore, is to examine drug expenditures by sector, such as hospital dispensing and physician dispensing. Third, OACT is attempting to estimate administrative costs. One approach being investigated is through physician self-reports of administrative hours. Finally, a long-run goal of both OACT and CBO is the development of a macro model of the interaction of the health care sector with the rest of the economy.

With the Medicare Fee Schedule scheduled to go into effect in January 1992, a number of cost studies are envisioned. The first would involve an assessment of the impact of the fee schedule on physicians in high reduction areas. The next two issues are related to the refinement of the current payment methodology, both getting behind the "black box" of the current work estimates and refining the overhead component for individual procedures/services. Finally, additional cost studies are required for outpatient procedures to develop a payment system that would bundle the facility fee, physician fee, and routine ancillary services. This would create a "level playing field" across sites of service.

Two topics were consistently mentioned regarding physician practice arrangements. The first concerns the physician's relationship within a group -- how income is distributed, salaries are determined, and expenses are allocated. The second concerns physician-hospital relationships, including compensation arrangements, exclusive contracting, and services provided by the hospital. Both types of information are critical to understanding physician practice costs, especially when they are self-reported.

A wide range of basic research studies, with potential payment policy implications, were mentioned. First and foremost, there is considerable interest in studies that would determine the cost structure of an efficient practice, and then setting fees at the level of the efficient practice. However, prior to changing the payment system, a number of other studies are required to understand how costs vary according to payor mix, size of practice, and

level of managed care involvement. Moreover, the impact on rural practices (especially those in remote rural areas) needs to be considered. Finally, variations in practice costs need to be examined according to site of service. For example, physicians who perform office-based surgery are likely to have different cost structures than those who perform surgery in an ambulatory surgery center or hospital facility.

Two topics fall under the general rubric of "Medicare in context." It was recommended that more attention be focused on revenues, costs, prices, and profits for the physician sector in general, not just the Medicare piece. The analogy was drawn to the PPS impact studies that examined overall hospital performance, not just the Medicare component. The measurement of administrative costs of a multipayor system is currently a "hot topic", for which little data exists to provide sound estimates.

Finally, three areas for further methodological work were discussed. The first involves validating physician self-reports of practice costs against an external source. The second would address how physicians allocate group costs according to their "own" share. The AMA Socioeconomic Monitoring System asks group practice physicians for their share of the group's medical expenses. How do physicians determine their share? Lastly, concerns have been raised about the multitude of cost studies that are likely to be sponsored by specialty societies. A desirable goal would be to develop a consistent methodology for follow-up cost studies, to improve their utility and consistency.

DATA SOURCES

Once we identified the needs for physician practice cost data, the discussion turned to potential sources for such data. Exhibit 4 lists the data sources identified during the needs assessment interviews, along with strengths and weaknesses that were mentioned by the key informants.

Currently, HCFA relies primarily on the 1988 Physicians' Practice Costs and Income Survey (PPCIS) and the American Medical Association's Socioeconomic Monitoring System (SMS) for information on physician practice costs. The key advantage of the PPCIS

EXHIBIT 4

SOURCES OF PHYSICIAN PRACTICE COST DATA

Source	Strengths	Weaknesses
HCFA Physicians' Practice Costs and Income Survey	• HCFA's "own" survey • Nationally representative sample	• Periodic survey • Very expensive to conduct • Requires OMB clearance • No validation of self-reported data • Limitations for subnational analyses • Considered difficult to tabulate; also concerns about "nonsense data"
AMA Socioeconomic Monitoring System	• Cooperative with HCFA for special tabulations and new questions • Physician cooperation likely to remain high • Nationally representative sample • Annual survey • Quick turnaround on special requests	• Uncertainty regarding data quality, statistical properties • Lack of practice cost detail on physician employee expenses; also fringe benefits and deferred compensation • Uncertainty about how physicians allocate group expenses to "own share" • No validation of self-reported data • Limitations for subnational analyses
Medical Economics' Continuing Survey	• Conceptually allows allocation of costs by direct and indirect-split of clinical and administrative personnel costs	• Predominantly medians in the published literature (raises questions about outliers and overall data quality) • Small samples • Low response rates; questions about representativeness of sample

EXHIBIT 4

SOURCES OF PHYSICIAN PRACTICE COST DATA
(continued)

Source	Strengths	Weaknesses
Medical Group Management Association —Cost and Production Survey —Physician Compensation Survey	• Depth of cost information • Number of responding physicians/ practices quite high	• Response rates quite low; no information on generalizability • Uncertainties regarding data quality; statistical properties • Unknown access to data
Census of Service Industries --Service Annual Survey --Assets and Expenditures Survey	• Will cooperate with HCFA to modify instruments (but only if HCFA commits resources) • Annual survey with detailed supplement every four years • Potential to tie to Medicare UPIN or Provider ID	• Limited sample sizes for physician offices • Receipts and expenditures are not reconciled (two separate surveys) • Limited detail for certain cost categories (e.g., malpractice)
IRS Business Masterfile	• Tabulations can be performed by state • IRS cooperative as long as HCFA is willing to pay	• Data not cleaned; if data elements do not affect collection of taxes, may not be accurate • Includes revenue from outside physician practice (e.g., rental income, oil well depletion allowance) • Problems with SIC code; if majority of income from non-MD practice (e.g., oil wells) would be classified in other industry (e.g., mining)
Urban Institute Survey of Malpractice Insurers	• High response rates • More representative than information from a single insurer per state	• Considerable effort involved in contacting insurers (100-125 phone contacts) • Requires OMB clearance • Insurers cannot readily provide historical rate information; future surveys should gather current rates

EXHIBIT 4

SOURCES OF PHYSICIAN PRACTICE COST DATA
(continued)

Source	Strengths	Weaknesses
CHPS Resource Cost Study	• Comparability of information across settings (48 ASCs, 48 OPDs, 48 MD Offices) • Detailed input cost data at "visit" level • Accuracy of cost information	• Limitations of generalizability due to sample sizes • Expensive process relative to sample sizes

is that it is HCFA's own survey, and the contents and sample can be tailored to HCFA's particular data needs. In addition, access to the data is not an issue. The AMA has made the SMS data more accessible to HCFA in recent years, running special tabulations for OACT as well as adding questions to the survey instrument for a very modest fee. Those who had worked with the AMA were unanimous in commending the AMA staff for their cooperation in meeting HCFA's data needs. The concerns, however, include uncertainties about the statistical properties of the data in general and about the practice cost data in particular (how do physicians allocate their share of the group's practice costs?). The practice cost data also do not include all of the categories of interest for the MEI and there was some question as to whether the SMS could be burdened with the additional detail required for physician employee expenses and physician fringe benefits and deferred compensation.

The next two sources, the Medical Economics' Continuing Survey and the Medical Group Management Association Surveys, have been used very little for practice cost studies, primarily due to questions raised by published data and lack of access to raw data. Both have low response rates, although the number of physicians represented in the MGMA surveys is exceedingly high.

Two new Federal sources of practice cost data were identifed during the needs assessment interviews. The Census of Service Industries contains a Service Annual Survey on receipts of physician offices (SIC 801) as well as other practitioners and facilities (SIC 802-808). A detailed supplement on assets and expenditures is fielded every four years. The possibility has been raised of linking with the UPIN or Provider ID. The current limitations of the surveys include small sample sizes, limited detail for certain cost categories, and lack of reconciliation between receipts and expenditures. However, the Census Bureau reportedly has indicated a willingness to work with HCFA to augment the sample or modify the content of the survey, if HCFA can commit funds to the effort.

The IRS Business Masterfile is another potential source of data on physician practice costs. The IRS, too, is apparently willing to work with HCFA if HCFA can commit funds to the data collection. Some of the disadvantages mentioned by key informants include potential

data inaccuracies, particularly for items not used for the collection of taxes; inclusion of revenue from non-medical activities; and misclassification of the SIC code, particularly if physicians have substantial amounts of income from non-practice sources.

Finally, HCFA is currently sponsoring two studies that might serve as models for special studies related to practice costs. The Urban Institute is currently conducting a Survey of Malpractice Insurers to develop better estimates of malpractice premiums by state. The researchers have had high response rates and conclude that the data are more representative than information from a single insurer per state. However, they encountered lengthy delays for OMB clearance and have found that the survey requires a considerable level of effort (100-125 calls). In addition, they found that insurers have difficulty providing historical information about premiums, necessitating surveys of current rates. The Center for Health Policy Studies recently received funding to perform a study of the resource costs for outpatient services. This study will develop methods to identify resources used for selected high volume procedures/services and then gather data on unit costs. The goal is to identify the aggregate and procedure/service specific costs of outpatient facility activities. Although this study is designed to support the development of an outpatient PPS, the methods have numerous applications to allocating practice overhead to procedures/services and understanding variations in practice costs.

DATA STRATEGIES

This section synthesizes the discussions with key informants concerning data strategies that can be pursued to meet current and future data needs. Exhibit 5 presents a list of potential data strategies. The items appear in no particular order.

The most commonly cited strategy was to work with the AMA to "adapt" the SMS to meet Federal data needs. Among the options would be to enlarge the sample or to add specific questions. In fact, OACT is currently working with the AMA to add a series

EXHIBIT 5

STRATEGIES FOR OBTAINING PHYSICIAN PRACTICE COST DATA

- Work with the American Medical Association (AMA) to adapt the Socioeconomic Monitoring System to meet Federal data needs (e.g., enlarge sample, add questions)

- Explore the utility of the Medical Group Management Association (MGMA) surveys on group practice costs and production and physician compensation

- Provide funding to the Census Bureau to expand sample sizes and modify questions on the Assest and Expenditure Survey and the Services Annual Survey (e.g., to collect malpractice data; link with Medicare UPIN)

- Obtain data from the Internal Revenue Service (IRS) on physician practice costs and incomes; explore possibility of matching specialty with HCFA or carrier files based on EIN/SSN

- Perform another round of PPCIS, drawing sample based on UPIN, to be able to relate survey responses back to claims

- Obtain data on physician fees directly from payors, rather than physicians (possible sources would be HIAA or MEDSTAT)

- Perform resource costing studies, for example, to validate physician self-reports of practice costs; determine physician practice costs by procedure/service; more accurately assess administrative cost impact of multipayor system; determine differences in practice costs according to type of practice (size, payor mix, managed care involvement); develop bundled payments for outpatient services taking into account differences across sites

- Use Delphi Panel of physicians, either to allocate overhead to procedures/services, followed by resource costing of individual input costs, or vice versa, to resolve conflicts encountered in resource costing analysis

- Conduct focus groups with urban and rural physicians to ascertain limits on practice efficiency (economies of scale and scope)

- Develop Physician Practice Cost Reports (analagous to the Medicare Cost Reports submitted by hospitals), for all or sample of Medicare practices, to be audited by HCFA, to assure accuracy of reported costs

of questions on physician revenues obtained from the hospital that are not tied to fee-for-service. The cost of this approach is certainly a lot lower than fielding another round of the PPCIS. (Proponents of the PPCIS, however, cite the advantage of HCFA access to the data and control over the content and sample as the major reasons to consider HCFA sponsorship of another survey.)

Other data sources could be explored further, namely the Medical Group Management Association Cost and Production and Compensation surveys, the Census Bureau surveys, and the IRS Business Masterfile. Data quality and data access are two key issues that would need to be investigated. Data on physician fees are available from existing sources, particularly the HIAA and MEDSTAT.

New approaches to collecting practice cost data were mentioned, including (1) applying resource costing methods to gathering information on resource use and unit costs and (2) conducting Delphi Panels/Focus Groups with physicians. The resource costing approach has a number of potential uses, for example, to assess administrative costs, to determine differences in practice costs according to selected practice characteristics, and to allocate overhead for selected procedures/services. Delphi Panels and Focus Groups can be used in conjunction with resource costing studies, both in the front-end (to identify inputs to specific procedures/services) and the back-end (to resolve conflicts raised in resource costing analysis). In addition, focus groups could be used to ascertain limits on practice efficiency among urban and rural physicians.

The final approach -- labelled the "worst case scenario" -- is to develop cost reports for physician practices (akin to the cost reports mandated for hospitals). The disadvantage to this approach is the sheer number of physician practices that would need to report and the effort involved in auditing even a sample of physician practices. Nevertheless, this would provide a rich source of cost information and would enable a wide range of sophisticated studies on revenues, costs, profits, etc.

NEXT STEPS

This needs assessment study has identified data needs, data sources, and data strategies, based on face-to-face interviews with key informants within HCFA and other Federal agencies and organizations. This is the first phase of a study designed to develop a comprehensive strategy for HCFA with respect to physician practice cost data. In addition, CHER is preparing a data inventory which will summarize the features and availability of nearly 50 public and private data bases dealing with physician data. Also, part of this study, CHER will perform methodological research to cumulate samples from three physician practice cost surveys -- the 1988 PPCIS, the 1989 SMS, and the 1987 PPRC Survey of Physicians. The goal is to determine whether individual samples can be combined to improve the analytic capability in the area of physician practice costs. During the final phase of the project, we will convene a Technical Advisory Panel to review the needs assessment report, data inventory, and methodological study. The goal is to develop a consensus concerning strategies for HCFA in meeting its current and future data needs.